

Patient's Name: _____ Date of Birth: _____

Home Address: _____
Street City State Zip Code

Home Phone: (____) _____ Work Phone: : (____) _____

Sex: M / F Age: _____ Height: _____ Weight: _____ lbs. Neck Size: _____

	<u>Y</u>	<u>N</u>	<u>Comments</u>
Do you snore?	<input type="radio"/>	<input type="radio"/>	_____
Does your Bed-partner say you snore:	<input type="radio"/>	<input type="radio"/>	_____
Do you stop breathing while you're asleep?	<input type="radio"/>	<input type="radio"/>	_____
Does your Bed-partner say you stop breathing?	<input type="radio"/>	<input type="radio"/>	_____
Are you sleepy during the day?	<input type="radio"/>	<input type="radio"/>	_____
Do you wake up with a headache?	<input type="radio"/>	<input type="radio"/>	_____
Do you Nap during the day?	<input type="radio"/>	<input type="radio"/>	_____
Any problems with sleepiness while driving?	<input type="radio"/>	<input type="radio"/>	_____
Do your legs move a lot when you sleep?	<input type="radio"/>	<input type="radio"/>	_____
Does your Bed-partner say your legs move:	<input type="radio"/>	<input type="radio"/>	_____
Do you act out while dreaming?	<input type="radio"/>	<input type="radio"/>	_____
Does your Bed-partner say you act out while dreaming:	<input type="radio"/>	<input type="radio"/>	_____

Have you ever had a prior sleep study? _____ **If so, where and when did you have it?** _____

Do you wear oxygen when you sleep?
If yes, at what setting? _____

Do you wear a CPAP/BIPAP?
If yes, at what setting? _____

What time do you go to bed? _____ What time do you normally wake up? _____

Do you have any medical conditions? _____ If yes, please list them: _____

Do you take any medications? _____ If yes, please list them with the dosage: _____

Northern Virginia Sleep Diagnostic Center @ Fairfax
8503 Arlington Blvd., Suite 340, Fairfax, Va. 22031
Telephone #: 703-645-2244 / Fax #: 703-645-0711
Please return completed questionnaire